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CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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CHAPTER IV

COVERED SERVICES AND LIMITATIONS

The Virginia Medicaid Program covers a variety of substance use disorder treatment services under the Addition and Recovery Treatment Services (ARTS) benefit for eligible members. This chapter describes these services and the requirements for the provision of those services.

All ARTS providers are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with the MCOs, MMPs and the BHSA and state and federal regulations.

GENERAL INFORMATION

Medallion 3.0 Managed Care Organizations (MCOs)

Medallion 3.0 is a statewide mandatory Medicaid program for Medicaid and FAMIS members. These contracted Managed Care Organizations (MCOs) provide medical and traditional behavioral health services including psychiatric and therapy services in outpatient and inpatient settings, and pharmacy services to qualified members. The Medallion 3.0 MCOs serve primarily children, pregnant women and adults who are not enrolled in Medicare. The program is approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver. Effective April 1, 2017, the Medallion 3.0 MCOs under contract with DMAS are responsible for the management and direction of the Addiction and Recovery Treatment Services (ARTS) benefit for their enrolled members.

Additional information about the Medicaid MCO Medallion 3.0 program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

Commonwealth Coordinated Care – Medicare and Medicaid Plans (MMPs)

The Commonwealth Coordinated Care (CCC) program is a demonstration program operating under a three way contract with DMAS, the contracted Medicare and Medicaid Plans (MMPs), and the Centers for Medicare and Medicaid Services (CMS). These MMPs coordinate care for members who are dually eligible for Medicare and Medicaid many of whom receive their services in a nursing facility or through a Home and Community Based Waiver. The program operates under 1932 (a) authority and includes the delivery of acute and primary medical care, behavioral health, pharmacy, and long-term services and supports. Effective April 1, 2017, the CCC MMPs under contract with DMAS are responsible for the management and direction of the ARTS benefit for their enrolled members.

Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-home.aspx to learn more.

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Behavioral Health Services Administrator (BHSA)

Magellan Health serves as the DMAS contracted Behavioral Health Services Administrator or "BHSA". The BHSA is responsible for the management of the behavioral health benefits program and ARTS benefit for fee-for-service members in Medicaid, FAMIS and the Governor's Access Plan (GAP).

Providers under contract with Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at <https://www.magellanprovider.com/MagellanProvider>.

All ARTS providers are responsible for adhering to the ARTS regulations, this manual, their provider contract with the MCOs/MMPs and the BHSA, and state and federal regulations.

Freedom of Choice

According to federal requirements (Section 1902(a)(23) of Title XIX of the Social Security Act (the Act)), fee-for-service Medicaid (including Family Access to Medical Insurance Security Plan (FAMIS) Plus and FAMIS) eligible members must be offered a choice of service provider(s) and this must be documented in the member's file. The MCOs and MMPs do not have to offer a freedom of choice per this requirement however shall offer the member freedom of choice among network providers [42 C.F.R. 438.10(e)(2)(vi)].

Transportation Benefits

Non-Emergency Medical Transportation (NEMT) is transportation of a Medicaid member to a non-emergency Medicaid-covered service. NEMT is not transportation where emergency services are required. Members should dial 9-1-1 if immediate response is needed for emergencies or worsening conditions that threaten life or limb.

Medicaid covers non-emergency Medicaid transportation to ARTS covered services. Click [here](#) for the Virginia Medicaid Fee-for-Service (FFS), Medallion 3.0 MCOs and the Commonwealth Coordinated Care (CCC) MMPs NEMT toll free contact telephone numbers. For specific questions and to coordinate transportation services for members enrolled in a MCO or MMP, please contact the specific MCO/MMP.

Telemedicine Services

DMAS reimburses for telemedicine services under limited circumstances. Telemedicine is the real-time or near real-time exchange of information for diagnosing and treating medical conditions. Telemedicine utilizes audio/video connections linking medical practitioners in one locality with medical practitioners in another locality. DMAS recognizes telemedicine as a

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means for delivering some covered Medicaid services. Please refer to the Virginia Medicaid Memo dated May 13, 2014: "Updates to Telemedicine Coverage". Medicaid Memos are posted at: <https://www.virginiamedicaid.dmas.virginia.gov> under Provider Services.

MCO/MMP contracted providers should consult with the contracted MCOs and MMPs for their specific policies and requirements for telemedicine.

Crisis Intervention

Crisis Intervention (H0036) is covered for both substance use disorder and/or mental health crises through the Community Mental Health Rehabilitation Services Program for all eligible members. Crisis Intervention is carved out of the MCO contracts and covered by the BHSA for eligible members. Crisis Intervention is covered by the MMPs. Provider should contact the MMPs or the BHSA (refer to the Community Mental Health Rehabilitation Services Program Provider Manual) for specific coverage requirements for Crisis Intervention.

Definitions

"Addiction" means, as defined by the ASAM, a primary, chronic disease of brain reward, motivation, memory and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

"Addiction-credentialed physician" as defined by ASAM means a physician who holds a board certification in addiction medicine from the American Board of Addiction Medicine, a subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology, or subspecialty board certification in addiction medicine from the American Osteopathic Association. In situations where a certified addiction physician is not available, physicians treating addiction should have some specialty training or experience in addiction medicine or addiction psychiatry. If treating adolescents, physicians should have experience with adolescent medicine.

"Adherence" means, as defined by ASAM, the member receiving treatment has demonstrated his ability to cooperate with, follow, and take personal responsibility for the implementation of his treatment plans.

"Adolescent" means a member from 12 to 20 years of age.

"Allied Health Professional" as defined by ASAM, includes counselor aides or group living workers.

"ARTS Care Coordinator" means an employee of the BHSA, MMP or MCO who is a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical

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psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist, nurse practitioner or registered nurse with two years of clinical experience in the treatment of substance use disorders, who has role to perform an independent assessment of requests for all ARTS residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0).

“ASAM Criteria” means the clinical guidelines developed by the American Society of Addiction Medicine (ASAM) to improve assessment and outcomes-driven treatment and recovery services. The ASAM Criteria seeks to de-emphasize the notion of “placement” and to respond to advances in clinical knowledge, practice, and public policy. In general, the purpose of the ASAM Criteria is to enhance the use of multidimensional assessments to develop person-centered service plans. It also includes the conceptual framework of Recovery-Oriented Systems of Care to facilitate understanding of addiction treatment services within a recovery-oriented “chronic disease management” continuum, rather than repeated and disconnected “acute episodes of treatment” for the acute complications of addiction; and/or repeated and disconnected readmissions to addiction or mental health programs that employ rigid lengths of stay into which members are “placed.”

"ASAM Criteria dimensions" means the six different life areas used by ASAM to develop a holistic biopsychosocial assessment of a member that is used for service planning, level of care determination, and length of stay treatment decisions.

"Assertive Community Treatment (ACT)," or "Intensive Community Treatment" means, the same as defined in 12VAC30-50-226.

“Behavioral health services administrator" or "BHSA" means the entity that manages the behavioral health benefits program under contract with DMAS for those members in fee for service and services for Medallion 3.0 and CCC that are carved out of the managed care contracts. DMAS' designated BHSA is authorized to constitute, oversee, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. DMAS shall retain authority for and oversight of the BHSA entity or entities.

"Buprenorphine Waivered Practitioners" means health care providers licensed under Virginia law and registered with the Drug Enforcement Administration (DEA) to prescribe schedule III, IV, or V medications for treatment of pain. Practitioners shall have completed the buprenorphine waiver training course and obtained the waiver to prescribe or dispense buprenorphine for opioid use disorder required under the Drug Addiction Treatment Act of 2000 (DATA 2000). Practitioners shall have been issued a DEA-X number by the DEA to prescribe buprenorphine for the treatment of opioid use disorder. Practitioners who are not physicians must meet all federal and state requirements and be supervised by or work in collaboration with a qualifying physician who is buprenorphine waived.

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"Care coordination" means collaboration and sharing of information among health care providers, who are involved with a member's health care to improve the care.

"Child" means a member from birth up to 12 years of age.

"Clinical experience" means, for the purpose of these ARTS requirements, practical experience in providing direct services to members with diagnoses of substance use disorder. Experience shall include supervised internships, supervised practicums, or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience.

"Code" means the Code of Virginia.

"Collateral services" means services provided by therapists or counselors for the purpose of engaging persons who are significant to the member receiving substance use disorder services. The services are focused on the member's treatment needs and support achievement of his recovery goals.

"Co-location" is the shared practice setting for the buprenorphine waived practitioner and the credentialed addiction treatment professional within an Office Based Opioid Treatment or Opioid Treatment Program services. This can be the same office, facility, building complex or campus.

"Co-occurring disorders" means, as defined by ASAM, the presence of concurrent substance use disorder and mental illness without implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other. Other terms used to describe co-occurring disorders include "dual diagnosis," "dual disorders," "mentally ill chemically addicted" (MICA), "chemically addicted mentally ill" (CAMI), "mentally ill substance abusers" (MISA), "mentally ill chemically dependent" (MICD), "concurrent disorders," "coexisting disorders," "comorbid disorders," and "members with co-occurring psychiatric and substance symptomatology" (ICOPSS). DMAS uses the term co-occurring disorders to include all of these terms.

"Credentialed addiction treatment professionals " includes the following and must act within their scope of their practice: an addiction-credentialed physician or physician with experience in addiction medicine; licensed psychiatrist; licensed clinical psychologist; licensed clinical social worker; licensed professional counselor; licensed psychiatric clinical nurse specialist; licensed psychiatric nurse practitioner; licensed marriage and family therapist; licensed substance abuse treatment practitioner; or "Residents" under supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10) or licensed substance abuse treatment practitioner (18VAC115-60-10) approved by the Virginia Board of Counseling; "Residents in psychology" under supervision of a licensed clinical psychologist approved by the Virginia Board of Psychology (18VAC125-20-10); "Supervisees in social work" under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work (18VAC140-20-10); and an individual with certification as a substance abuse

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counselor (CSAC) (18VAC115-30-10) or certified substance abuse counselor-assistant (CSAC-A) (18VAC115-30-10) under supervision of a licensed provider.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"DHP" means the Department of Health Professions.

"DMAS" or "the department" means the Department of Medical Assistance Services and its contractor or contractors consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

"Evidence-based practice" means an empirically-supported clinical practice or intervention with a proven ability to produce positive outcomes.

"FAMIS" means the Family Access to Medical Insurance Security as set out in 12 VAC 30-141 et seq.

"FQHC" means Federally Qualified Health Center.

"Individual" means the patient, client, beneficiary or member who receives services set out in 12 VAC 30-130-5000 et seq. These terms are used interchangeably.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-130-5020.

"Induction Phase" means the medically monitored startup of buprenorphine treatment performed in a qualified physician's office or certified OTP using approved buprenorphine products. The goal of the induction is to find the patient's ideal daily dose of buprenorphine. The ideal daily dose minimizes both side effects and drug craving. For most opioid-dependent patients, the daily dose is 12 to 16 mg/day of the buprenorphine+ naloxone combination film or tablet. Induction usually takes 2 to 4 days to complete.

"Licensed practical nurse" or "LPN" means a professional who is either licensed by the Commonwealth or who holds a multi-state licensure privilege to practice nursing (18 VAC 90-20-10 et seq.).

"Maintenance treatment or treatments," means pharmacotherapy on a consistent schedule for members with addiction, usually with an agonist or partial agonist, which mitigates against the pathological pursuit of reward or relief, or both, and allows remission of overt addiction-related problems. Maintenance treatments of addiction are associated with the development of a pharmacological steady state in which receptors for addictive substances are occupied, resulting in relative or complete blockade of central nervous system receptors such that addictive substances are no longer sought for reward or relief. Maintenance treatments of addiction are also designed to lessen the risk of overdose. Depending on the circumstances of a given case, an ISP including maintenance treatments can be time-limited or can remain in place for life as long as clinically indicated. Integration of pharmacotherapy via maintenance treatments with

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psychosocial treatment generally is associated with the best clinical results. Maintenance treatments can be part of a member's ISP in abstinence-based recovery activities or can be a part of harm reduction strategies.

"Managed Care Organization" or "MCO" means an organization which offers managed care health insurance plans (MCHIP), as defined by *Code of Virginia* § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. For the purposes of this manual, MCO refers to those health plans contracted with DMAS to provide services to Medallion 3.0 members.

"Medicare-Medicaid Plan" or "MMP" means a managed care organization who provides integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries. For the purposes of this manual, MMP refers to the health plans contracted with DMAS and CMS to provide services to Commonwealth Coordinated Care (CCC) members.

"Multidimensional assessment" means the individualized, person-centered biopsychosocial assessment performed face-to-face, in which the provider obtains comprehensive information from the member (including family members and significant others as needed) including: history of the present illness; family history; developmental history; alcohol, tobacco, and other drug use or addictive behavior history; personal/social history; legal history; psychiatric history; medical history; spiritual history as appropriate; review of systems; mental status exam; physical examination; formulation and diagnoses; survey of assets, vulnerabilities and supports; and treatment recommendations. The ASAM Multidimensional Assessment is a theoretical framework for this individualized, person-centered assessment that includes the following six dimensions: i) acute intoxication or withdrawal potential, or both, ii) biomedical conditions and complications, iii) emotional, behavioral, or cognitive conditions and complications, iv) readiness to change, v) relapse, continued use, or continued problem potential and vi) recovery/living environment.

"Office-based opioid treatment" or "OBOT" means addiction treatment services for members with moderate to severe opioid use disorders provided by buprenorphine-waivered practitioners working in collaboration with credentialed addiction treatment practitioners providing psychosocial treatment in public and private practice settings.

"Opiate" means, as defined by ASAM, one of a group of alkaloids derived from the opium poppy (*Papaver somniferum*) which has the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression but excludes synthetic opioids.

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"Opioid" means any psychoactive chemical that resembles morphine in pharmacological effects, including opiates and synthetic/semisynthetic agents that exert their effects by binding to highly selective receptors in the brain where morphine and endogenous opioids affect their actions.

"Opioid treatment program (OTP)" means a program certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) that engages in supervised assessment and treatment, using methadone, buprenorphine, L-alpha acetyl methadol, or naltrexone, of members who are addicted to opioids.

"Opioid treatment services (OTS)" means, as defined by ASAM, office based opioid treatment (OBOT) and Opioid Treatment Programs (OTP) which encompass a variety of pharmacological and non-pharmacological treatment modalities.

"Overdose" means, as defined by ASAM, the inadvertent or deliberate consumption of a dose of a chemical substance much larger than either habitually used by the member or ordinarily used for treatment of an illness which is likely to result in a serious toxic reaction or death.

"Physician extenders" means licensed nurse practitioners (18VAC90-30-10) and licensed physician assistants (18VAC85-50-10).

"Psychoeducation" means (i) a specific form of education aimed at helping members who have a substance use disorder or mental illness and their family members or caregivers to access clear and concise information about substance use disorders or mental illness and (ii) a way of accessing and learning strategies to deal with substance use disorders or mental illness and its effects in order to design effective ISPs and recovery strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an member's and his/her family's needs and focuses on increasing the member's and family's knowledge about substance use disorders and/or mental illness, recovery, communicating and facilitating problem solving and increasing coping skills.

"Psychosocial treatment" means any non-pharmacological intervention carried out in a therapeutic context within a substance use disorder treatment program, at a member, family, or group level which may include structured, professionally administered interventions (e.g., cognitive behavior therapy or insight-oriented psychotherapy) or nonprofessional interventions (e.g., self-help groups or peer-facilitated activities).

"Recovery" means, as defined by ASAM, a process of sustained effort that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction and consistently pursues abstinence, behavior control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and more effective coping with emotional responses leading to reversal of negative, self-defeating internal processes and behaviors and allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as follows: A process of change through which

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members improve their health and wellness, live a self-directed life, and strive to reach their full potential.

"Registered nurse" or "RN" means a professional who is either licensed by the Commonwealth or who holds a multi-state licensure privilege to practice nursing (18 VAC 90-20-10 et seq.).

"Relapse" means, as defined by ASAM, a process in which an member who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward or relief through the use of substances and other behaviors often leading to disengagement from recovery activities. Relapse can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. The event of using or acting out is the latter part of the process, which can be prevented by early intervention.

"Review of ISP" means that the service provider reads the ISP for any necessary changes, evaluates and updates the member's progress toward meeting the individualized service plan objectives, and documents the outcome of this review.

"RHC" means rural health clinic.

"SBIRT" means screening, brief intervention, and referral to treatment. Screening, Brief Intervention, and Referral to Treatment (SBIRT) services are an evidence-and community-based practice designed to identify, reduce, and prevent problematic substance use disorders. Per CMS, SBIRT is an early intervention approach that targets members with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of members with more severe substance use or those who meet the criteria for diagnosis of a substance use disorder.

"Service authorization" means the process to approve specific services for an enrolled Medicaid or FAMIS member by a MCO, MMP or the BHSA prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Approved service authorization does not guarantee payment for the service.

"Substance use care coordinator" means an member in an OTP or OBOT setting who has either: 1) at least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least either a) one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or b) a minimum of one year of clinical experience working with individual with co-occurring diagnoses of substance use disorder and mental illness ; or 2) Licensure by the Commonwealth as a registered nurse with at least either a) one year of direct experience providing services to individuals with a diagnosis of substance use disorder or b) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or 3) Board of Counseling

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Certified Substance Abuse Counselor (CSAC) or CSAC-Assistant under supervision as defined in 18VAC115-30-10 et seq.

"Substance use case management" means the same as set out in 12VAC30-50-491.

"Substance use disorder" or "SUD" means a disorder, as defined in the DSM 5, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the member continues to use alcohol, tobacco, or other drugs despite significant related problems.

"Telemedicine" or "Telehealth" means the practice of the medical arts via electronic means rather than face-to-face.

"Therapeutic passes" mean time at home or time with family consisting of partial or entire days of time away from the group home or treatment facility with identified goals as approved by the treating physician, psychiatrist, or the credential addiction treatment professional responsible for the overall supervision of the individual service plan and documented in the individual service plan that facilitate or measure treatment progress, facilitate aftercare designed to promote family/community engagement, connection and permanency, and provide for goal-directed family engagement.

"Tolerance" means, as defined by ASAM, a state of adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time.

"Withdrawal management" means, as defined by ASAM, services to assist a member's withdrawal from the use of substances.

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)

DMAS worked in conjunction with the Department of Health Professions (DHP), the Department of Behavioral Health and Developmental Services (DBHDS), Virginia Department of Health (VDH), MCOs, MMPs and stakeholders, to design a transformed delivery system for addiction and recovery treatment which is based on the American Society of Addiction Medicine (ASAM) standards. These changes will help to ensure the integration of high quality addiction treatment, physical health, and mental health services for Virginia's Medicaid and FAMIS enrolled members.

DMAS is utilizing the treatment criteria for addictive, substance-related conditions as published by the **ASAM (third edition 2013)**. The ASAM Criteria provides criteria for a wide range of levels and types of care for addiction and substance-related conditions and establishes clinical guidelines for making the most appropriate treatment and placement recommendations for members who demonstrate specific signs, symptoms and behaviors of addiction. ASAM includes a comprehensive system of multidimensional assessment, broad and flexible continuum of care, interdisciplinary team approach to care; and clinical and outcome-driven treatment is expected to substantially reduce the consequences of addiction. It also includes the conceptual framework of Recovery-Oriented Systems of Care to facilitate understanding of addiction treatment services within a recovery-oriented "chronic disease management" continuum, rather than repeated and disconnected "acute episodes of treatment" for the acute complications of addiction; and/or

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repeated and disconnected readmissions to addiction or mental health programs that employ rigid lengths of stay into which members are “placed.”

Services listed below are covered under the ARTS benefit and are reimbursable by the MCOs and MMPs for managed care enrolled members and through the BHSA for fee-for-service enrolled members. The chart describes the ARTS service coverage by ASAM Level of Care.

ASAM Level of Care	ASAM Description
4.0	Medically Managed Intensive Inpatient
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)
3.5	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)
3.1	Clinically Managed Low-Intensity Residential Services
2.5	Partial Hospitalization Services
2.1	Intensive Outpatient Services
1.0	Outpatient Services
1.0	Opioid Treatment Program (OTP)
1.0	Office-Based Opioid Treatment (OBOT)
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)
n/a	Substance Use Case Management

The ARTS specific procedure codes and reimbursement structure are documented in Chapter V of this manual.

This provider manual serves as the policy for providers of the new DMAS reimbursable ARTS benefit.

ELIGIBILITY FOR ARTS BENEFITS

Children and adults who participate in Medicaid and FAMIS managed care organizations (MCOs), Medicare-Medicaid Plans (MMPs) and fee-for-service - including the Governor’s Access Plan for the Seriously Mentally Ill (GAP) through the BHSA and DMAS, who meet ASAM medical necessity criteria shall be eligible for ARTS.

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Non-Covered Services

FAMIS/FAMIS MOMS enrolled members are not eligible for Residential Treatment Services (ASAM Levels 3.3 to 3.7) nor for services furnished in a state operated mental health hospital. FAMIS/FAMIS MOMS FFS enrolled members are not eligible for services provided in a free-standing private inpatient psychiatric hospital, however managed care plans may elect to cover as additional benefit for their members.

GAP enrolled members are not eligible for Inpatient services (ASAM Level 4.0), Residential Treatment Services (ASAM Level 3.7/3.5/3.3), Group Home (ASAM Level 3.1), Partial Hospitalization (ASAM Level 2.5) or Substance Use Case Management. GAP covered services are through the BHSA only. GAP members are not enrolled in Medicaid managed care plans.

MEDICAL NECESSITY CRITERIA

In order to receive reimbursement for ARTS services, the member shall be enrolled in Virginia Medicaid and shall meet the following medical necessity criteria below:

1. The member shall demonstrate at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Substance-Related and Addictive Disorders with the exception of tobacco-related disorders, caffeine use disorder or dependence, and non-substance-related addictive disorders; or be assessed to be at risk for developing substance use disorder (for youth under the age of twenty-one using the ASAM multidimensional assessment).
2. The member shall be assessed by a credentialed addiction treatment professional acting within the scope of their practice, who will determine if he/she meets the severity and intensity of treatment requirements for each service level defined by the most current version of the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (Third Edition, 2013). Medical necessity for ASAM Levels of Care 2.1 to 4.0 (Intensive Outpatient and Partial Hospitalization Programs, Residential and Inpatient Services) shall be based on the outcome of the member's documented multidimensional assessment. The following outpatient ASAM levels of care do not require a complete multidimensional assessment using the ASAM theoretical framework in order to determine medical necessity but do require an assessment and development of a documented individualized service plan (ISP) by a certified addiction treatment professional: Opioid Treatment Programs (OTP), Office Based Opioid Treatment (OBOT) including Substance Use Care Coordination, Substance Use Outpatient Services (ASAM Level 1) and Substance Use Case Management.
3. For members younger than the age of 21 who do not meet the ASAM medical necessity criteria upon initial assessment, a second individualized review by a licensed physician shall be conducted to determine if the member needs medically necessary treatment under the

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Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions, including SUD, discovered by the screening.

ARTS services shall integrate physical health and behavioral health services for a complete continuum of care for all Medicaid members meeting the medical necessity criteria. DMAS contracted MCOs, MMPs and the BHSA shall apply the ASAM criteria to review and coordinate service needs when administering ARTS benefits. The MCOs, MMPs and the BHSA shall use an ARTS care coordinator (licensed behavioral health professional), a licensed physician or medical director employed by the MCO, MMP or BHSA to perform an independent assessment of all requests for ARTS residential treatment services (ASAM Levels 3.1, 3.3, 3.5, 3.7) and ARTS inpatient treatment services (ASAM Level 4.0). The length of treatment and service limits shall be determined by the ARTS care coordinator, a licensed physician or medical director employed by the BHSA, MMP or MCO who is applying the ASAM criteria.

Multidimensional Assessment

DMAS requires a multidimensional assessment which shall be completed and documented by a credentialed addiction treatment professional acting within the scope of their practice, as defined in 12VAC30-130-5020, for ASAM Levels of Care 2.1 through 4.0 as described in the table earlier in this chapter. The multidimensional assessment, based on a biopsychosocial assessment, shall be maintained in the member's medical record by the provider. Medical necessity for all ASAM levels of care shall be determined based on the outcome of the member's multidimensional assessment.

The multidimensional assessment is a theoretical framework for this individualized, person-centered assessment that includes the following six dimensions:

- Acute intoxication or withdrawal potential, or both;
- Biomedical conditions and complications;
- Emotional, behavioral, or cognitive conditions and complications;
- Readiness to change;
- Relapse, continued use, or continued problem potential; and
- Recovery/living environment.

The Level of Care determination, Individual Service Plan (ISP) and recovery strategies development shall be based upon this multidimensional assessment.

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Co-occurring Addictive and Mental Health Disorders

ASAM issued a Public Policy Statement on Co-occurring Addictive and Psychiatric Disorders in December 2000: <http://www.asam.org/docs/default-source/public-policy-statements/1co-occurring-disorders-12-00.pdf?sfvrsn=0>

A co-occurring disorder is the presence of substance use and mental health disorders occurring simultaneously without implication as to the causal effect of one over the other, nor which disorder is primary versus secondary. Members who are experiencing a co-occurring substance use and mental health disorder may experience greater impairments in functioning. Thus providers who are trained and practicing within the scope of their practice, in working with members with both substance use and mental health disorders should ensure both conditions are addressed in treatment. If a provider is not trained in treatment of both substance use and mental health disorders, they should refer the member to an appropriate service provider. With a current signed consent and authorization to exchange/disclose personal health information, both providers should collaborate to coordinate effective treatment.

For persons with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment needs. There may be concurrent authorizations for psychiatric services and substance use disorder services if medical necessity criteria are met for the requested service. Collaboration and coordination of care among all treating practitioners shall be documented.

Providers shall use the ASAM recommendations stated in the Public Policy Statement above in evaluating and treating members. Providers shall incorporate in their multidimensional assessment or service specific provider intake (whichever is required for the service) of members the goal of identifying independent co-occurring disorders (both substance use and mental health disorders) for all members entering treatment. Providers shall use the ASAM Criteria to determine the appropriate levels of care.

INDIVIDUALIZED SERVICE PLAN (ISP)

The ISP is a comprehensive treatment plan specific to the member's unique treatment needs as identified in the assessment or the multidimensional assessment as applicable to the ASAM Level of Care. The ISP is person-centered, recovery oriented, includes all planned interventions, aligns with the member's identified needs and recovery goals, care coordination needs, is regularly updated as the member's needs and progress change, and shows progress throughout the course of treatment. The written ISP contains, but is not limited to, the member's treatment or training needs, the member's goals, measurable objectives and recovery strategies to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. For

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persons with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment needs in the member's ISP.

The adult member shall sign his or her own ISP and if unwilling or unable to sign the ISP, then the service provider shall document the reasons why the member was not able or willing to sign the ISP. The child's or adolescent's ISP shall be signed by the parent/legal guardian except in cases where a minor who is deemed an adult for purposes of consenting to medical or health services needed for treatment of substance use disorder services meets requirements per [§54.1-2969](#).

Documentation of the ISP review must be added to the member's medical record no later than 7 days from the calendar date of the review as evidenced by the dated signatures of the credentialed addiction treatment professional as noted above, and the member and/or guardian, when a minor child is the recipient (unless meeting [§54.1-2969](#)).

Discharge Planning

All ISPs for all levels of care shall include an individualized discharge plan. Anticipated discharge plans are documented at the start of treatment. The discharge plan describes the discharge planning activities, summarizes an estimated timetable to achieving the goals and objectives in the service plan, and includes discharge plans that are kept current and specific to the needs of the member. The discharge plan shall include plans for transitioning through appropriate levels of care until member reaches a point where they may exit the continuum of care and resume daily activities without the need for any ARTS intervention.

ISP Specific Requirements for ASAM Levels 4.0/3.7/3.5/3.3/3.1/2.5/2.1

In the settings below there are specific requirements that shall be followed for the ISP:

- Medically managed intensive inpatient services (ASAM 4.0);
- Substance use residential/inpatient services (ASAM levels 3.1, 3.3, 3.5, and 3.7); and
- Substance use intensive outpatient and partial hospitalization programs (ASAM levels 2.1 and 2.5).

The initial ISP shall be developed and documented within 24 hours of admission to the following services based on the ASAM multidimensional assessment to address the immediate service, health, and safety needs for the following programs:

- ASAM Level 4.0: The physician or the physician extender shall develop and document the initial ISP for inpatient services (ASAM Level 4.0).

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- ASAM Level 3.7 to 3.1: The credential addiction treatment professional(s), in collaboration with the physician or physician extender overseeing the treatment process, shall complete and document the initial ISP.
- ASAM Level 2.5 to 2.1): For substance use intensive outpatient and partial hospitalization programs, the credential addiction treatment professional(s) shall develop and document the ISP and include the physician and physician extender as necessary.

In cases where the member is not able to participate in the assessment process due to an acute medical condition and/or acute intoxication or impairment, the provider should note this in the member's record and include the member when they are able to participate.

The comprehensive ISP shall be fully developed and documented within 14 calendar days of the initiation of services and contemporaneously signed and dated by the credentialed addiction treatment professional(s) and the physician and/or physician extender, as necessary, preparing the ISP. The provider shall include the member and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the member's condition requires assistance for participation, assistance shall be provided.

ASAM Level 4.0/3.7/3.5/3.3/3.1/2.5: The ISP shall be reviewed every 30 calendar days in these ASAM Levels by the credentialed addiction treatment professional(s) to determine that services being provided are or were required at the specific ASAM Level of Care and to recommend changes in the plan as indicated by the member's overall adjustment during the placement. For settings that are medically managed versus clinically managed, the physician and/or physician extender should also review the ISP. The ISP shall be updated at least every 30 calendar days and as the member's needs and progress change. An ISP that is not updated either every 30 calendar days or as the member's needs and progress change shall be considered outdated.

ASAM Level 2.1: The ISP shall be reviewed every 90 calendar days in ASAM Level 2.1 by the credentialed addiction treatment professional(s) to determine that services being provided are or were required at ASAM Level 2.1 and to recommend changes in the plan as indicated by the member's overall adjustment during the placement. The ISP in ASAM Level 2.1 shall be updated at least every 90 calendar days and as the member's needs and progress change. An ISP that is not updated either every 90 calendar days or as the member's needs and progress change shall be considered outdated.

If the ISP review identifies any changes in the member's progress and treatment needs, the goals, objectives, and strategies of the ISP must be updated to reflect any changes in the member's progress and treatment needs as well as any newly-identified problems. The ISP shall include the signature and date from the member, parent, or legally authorized representative, credentialed addiction treatment professional(s) and the physician and/or physician extender, as necessary.

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Individual, group and family therapy shall be provided in accordance to the ASAM Criteria for the specific level of care, as directed by the member's ISP and based on the member's treatment needs as identified in the multidimensional assessment. Therapy shall be provided by credentialed addiction treatment professionals with in the scope of their practice, and which shall be documented in the ISP and progress notes in accordance with the requirements in this section. A week is defined as Sunday through Saturday.

Family engagement shall be provided in addition to family therapy/counseling as appropriate and outlined in the ISP. The family or legally authorized representative shall be part of the family engagement strategies in the ISP. Family engagement activities are considered to be an intervention and shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the ISP. Any deviation from the ISP shall be documented along with a clinical or medical justification for the deviation based on the needs of the member.

The ISP shall meet all of the following criteria:

- Be developed by credentialed addiction treatment professional(s) participating in the ASAM Level of Care who are employed by, or provide services to the member in the facility/program in consultation with the member, as well as collateral contacts or the member as appropriate such as family members or legally authorized representative, or appropriate others into whose care the member will be released after discharge;
- Be based on the multidimensional assessment including ASAM Dimensions 1-6 and a diagnostic clinical evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the member's situation and must reflect the need for the ASAM Level of Care;
- Be based on evidenced based assessment tools such as, but not limited to: Addiction Severity Index (ASI), Global Appraisal of Individual Needs (GAIN), or Social Assessment to gather clinical information;
- Describe any prior treatment information and testing that the member has received;
- Shall state treatment objectives that includes the member's goals that shall include measurable, evidence-based, short-term and long-term goals and objectives, family engagement activities (as appropriate), and the design of community-based aftercare with target dates for achievement;
- Describe the ASAM Dimensional Admission Criteria rules for the appropriate ASAM Level of Care being requested;
- Prescribe an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the member's treatment needs; and

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- Describe comprehensive transition plans and coordination of current care and post-discharge plans with related community services to ensure continuity of care upon discharge with the recipient's family, school, and community.

The member's medical record shall include:

- Member and family strengths, needs, abilities and preferences that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;
- Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the member;
- Measureable treatment objectives with short-term and long-term goals;
- Any orders for medications, psychiatric, medical, dental, and any special healthcare needs, whether or not provided in the facility, education or special education, treatments, interventions, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member and the staff person responsible for providing those services;
- Plans for continuing care, including review and modification to the ISP;
- Detailed discharge plan developed with the member; and
- Signature and date by the member or legally authorized representative, and the credentialed addiction treatment professional(s) participating in the treatment team.
- The provider shall request releases of information from the member or legally authorized representative to release confidential information to collect information from medical and behavioral health treatment providers, schools, social services, court services, and other relevant parties. This information shall be used when considering changes and updating the ISP.

ISP Specific Requirements for Opioid Treatment Services and ASAM Level 1.0

The initial ISPs shall be developed at first appointment to address the immediate service, health, and safety needs for the following:

- Opioid Treatment Services (OTP);
- Office Based Opioid Treatment (OBOT); and
- Substance Use Outpatient Services (ASAM level 1).

In these settings above, the comprehensive ISP shall be fully developed and documented within 30 calendar days of the initiation of services and contemporaneously signed and dated by the credentialed addiction treatment professional preparing the ISP. In these settings above, the ISP

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shall be reviewed at least every 90 calendar days and shall be modified as the needs and progress of the member changes. If the review identifies any changes in the member's progress and treatment needs, the goals, objectives, and strategies of the ISP must be updated to reflect any changes in the member's progress and treatment needs as well as any newly-identified problems.

Documentation of the ISP review shall include the dated signatures of the credentialed addiction treatment professional and the member. The provider shall include the member and the family/caregiver, as may be appropriate, in the development of the ISP or treatment plan. To the extent that the member's condition requires assistance for participation, assistance shall be provided.

The ISP shall be updated in writing at least annually and as the member's needs and progress change. An ISP that is not updated either annually or as the member's needs and progress change shall be considered outdated. The outcome of the review shall be documented. If the review identifies any changes in the member's progress and treatment needs, the goals, objectives, and strategies of the ISP must be updated to reflect any changes in the member's progress and treatment needs as well as any newly-identified problems.

ISP Specific Requirements for Substance Use Case Management

- Assessing needs and planning services to include developing a substance use case management ISP developed with the member, in consultation with the member's family, as appropriate as defined in 12VAC30-130-5020.
- An ISP shall be completed within 30 calendar days of initiation of this service with the member in a person-centered manner and shall document the need for active substance use case management before such case management services can be billed. The ISP shall require a minimum of two distinct substance use case management activities being performed each calendar month and a minimum of one face-to-face client contact at least every 90 calendar days.
- The substance use case manager shall review the ISP with the member at least every 90 calendar days for the purpose of evaluating and updating the member's progress toward meeting the ISP objectives. The review will be due by the 90th calendar day following the date the last review was completed. The reviews shall be documented in the member's medical record. DMAS will allow a grace period to be granted up to the 120th calendar day following the date of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled 90 calendar days from the date the review was initially due and not the date of actual review.
- The ISP shall be reviewed with the member present, and the outcome of the review documented in the member's medical record.
- The ISP shall be updated and documented in the member's medical record at least annually and as an member's needs change.

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COVERED SERVICES AND LIMITATIONS

In order to be covered, ARTS Services (as defined in 12VAC30-130-5000 et al) shall meet medical necessity criteria based upon the multidimensional assessment completed by a credentialed addiction treatment professional as defined in this manual, within the scope of their practice. ARTS Services shall be accurately reflected in provider medical record documentation and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

These ARTS services, with their service definitions, shall be covered:

- Medically Managed Intensive Inpatient Services (ASAM Level 4);
- Substance Use Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7);
- Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5);
- Opioid Treatment Services (Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT);
- Substance Use Outpatient Services (ASAM Level 1);
- Early Intervention Services/SBIRT (ASAM 0.5);
- Substance Use Care Coordination; and
- Substance Use Case Management Services.

Withdrawal Management services shall be covered when medically necessary as a component of the following:

- Medically Managed Inpatient Services (ASAM Level 4);
- Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7);
- Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5);
- Opioid Treatment Services (Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT); and
- Substance Use Outpatient Services (ASAM Level 1).

ARTS Service Authorization and Registration

Service authorization is the process to determine medical necessity for specific ARTS services for an enrolled Medicaid/FAMIS member by the MCOs, MMPs or BHSA prior to service

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delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and the ASAM criteria for authorization. Service authorization does not guarantee payment for the service. Providers need to verify the member's benefit eligibility prior to initiating services to ensure the service being requested is covered under the particular benefit. This is required as GAP and FAMIS members are not eligible for all ARTS benefits as noted earlier in this Chapter under "Eligibility for ARTS Benefits". The medical record content shall corroborate the information provided to the DMAS service authorization contractor, contracted MCO, or MMP, or BHSA.

The ARTS Service Authorization Review Form for initial requests as well as the ARTS Service Authorization Extension Review Form for requests for extensions for the same ASAM level are located online at: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx. Providers should submit to the health plans via the fax number listed for the appropriate health plan on the service authorization form, and upload the service authorization form to Magellan for fee-for-service members. Providers are encouraged to submit the completed service authorization forms prior to or at initiation of services. Requests for service authorizations that do not meet the ASAM requirements for the requested level of care will not be approved.

ARTS Service Authorization Requirements:

ASAM Level of Care	ASAM Description	Service Authorization Required?
4.0	Medically Managed Intensive Inpatient	Yes
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	Yes
3.5	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)	Yes
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	Yes
3.1	Clinically Managed Low-Intensity Residential Services	Yes
2.5	Partial Hospitalization Services	Yes
2.1	Intensive Outpatient Services	Yes
1.0	Outpatient Services	No
1.0	Opioid Treatment Program (OTP)	No
1.0	Office-Based Opioid Treatment (OBOT)	No
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)	No
n/a	Substance Use Case Management	Registration Required

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Substance Use Case Management requires registration with the MCOs, MMPs and the BHSA as defined by their contract with the MCO/MMP or BHSA.

- Magellan utilizes the “Virginia DMAS Registration” form available: <http://www.magellanoftexas.com/for-providers-tx/forms.aspx>. The MCOs and the
- MMPs utilize the “ARTS Substance Use Case Management Registration” form available: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.

DMAS Recommended Timeframes for Submission of the Service Authorization or Registration*:

Service	Time Frame for Submission to MCO/MMP/BHSA	Form
Substance Use Case Management	2 business days from service initiation.	MCOs and MMPs: ARTS Substance Use Case Management Registration Form Magellan: Virginia DMAS Registration Form
ASAM 2.1 to 4.0 – Initial Request	1 business day from service initiation but no greater than 5 calendar days prior to service initiation.	ARTS Service Authorization Request
ASAM Level 2.1 to 4.0 – Extension Request	Submitted prior to current service authorization ending but no greater than 5 calendar days prior to service authorization end date. If submitted after the current service authorizations ends, MCOs/MMPs/BHSA will honor begin date of extension, based on the day of receipt.	ARTS Service Authorization Request for Extensions

*Magellan will follow these specific DMAS recommendations. The MCOs and MMPs will follow the requirement of the National Committee for Quality Assurance (NCQA).

Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5)

Early intervention (ASAM Level 0.5) / Screening, Brief Intervention, and Referral to Treatment (SBIRT) services may be provided in a variety of settings including: local health departments, FQHCs, rural health clinics (RHCs), Community Services Boards (CSBs)/ Behavioral Health Authorities (BHAs), health systems, emergency departments of hospitals, pharmacies, physician’s offices, and private and group outpatient practices. The individual practitioners conducting the screenings shall include credentialed addiction treatment professionals as well as pharmacists, and either directly contracted and credentialed by the MCOs, MMPs or the BHSA

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to perform this level of care, or employed by organizations that are contracted by the MCOs, MMPs or the BHSA.

Early intervention/SBIRT (ASAM Level 0.5) service components shall include (as defined in 12VAC30-130-5140):

- Identifying members who may have alcohol or other substance use problems using an evidence-based screening tool.
- Following the evidence-based screening tool, a brief intervention by a licensed professional acting within the scope of their practice, shall be provided to educate members about substance use, alert these members to possible consequences and, if needed, begin to motivate members to take steps to change their behaviors.

Service Units and Limitations

CPT Code	Description
99408	SBIRT - Alcohol and/or substance use structured screening: 15 - 30 minutes
99409	SBIRT - Alcohol and/or substance use structured screening: greater than 30 minutes

SBIRT services do not require service authorization. There are no annual service limits.

Opioid Treatment Services (OTS)

Opioid Treatment Services and Medication Assisted Treatment (MAT) are allowable and can be billed separately in community-based settings providing ASAM Levels 1.0 through 3.7 (excluding inpatient services). See Exhibits for MAT Services. Practitioners of MAT must follow the Board of Medicine regulations for provisions for prescribing of buprenorphine for addiction treatment (12VAC85-21-130 to 170). Collaboration must occur between the community-based provider and the buprenorphine-waivered practitioner. Practitioners who are not licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as an Opioid Treatment Program (OTP) or approved by DMAS as an Office Based Opioid Treatment (OBOT) provider and credentialed with the MCOs, MMPs or the BHSA as an OTP or OBOT, will have service authorization requirements for prescribing buprenorphine products, including oral buprenorphine, short-acting opioids and long acting opioids.

Those providers who are licensed as an OTP or approved by DMAS as an OBOT must meet the additional requirements below. These requirements need to be met and also credentialed with the MCOs, MMPs or the BHSA as an OTP or OBOT to have these additional benefits:

- No service authorization for buprenorphine products;
- Higher reimbursement of Practitioner Induction – Day 1 and psychotherapy sessions; and
- Eligible for reimbursement for Substance Use Care Coordination.

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Opioid Treatment Programs (OTP)

OTPs shall meet the service components and risk management requirements outlined below and as defined in 12VAC30-130-5120.

OTP service components include the following activities. Providers shall document the provision of the following activities, as rendered, in the member's medical record:

- Link the member to psychological, medical, and psychiatric consultation as necessary to meet the member's needs.
- Ensure access to emergency medical and psychiatric care through connections with more intensive levels of care.
- Ensure access to evaluation and ongoing primary care.
- Conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.
- Ensure appropriately licensed and credentialed physicians are available to evaluate and monitor use of methadone, buprenorphine products or naltrexone products and of pharmacists and nurses to dispense and administer these medications.
- Ensure buprenorphine monoproducts are prescribed only to pregnant women or for 7 days while transitioning members from methadone to buprenorphine/naloxone. All other members should receive buprenorphine/naloxone or naltrexone products. The maximum daily buprenorphine or buprenorphine/naloxone dose should be 16 mg unless there is documentation of an ongoing compelling clinical rationale for a higher maintenance dose up to maximum of 24 mg. In rare and isolated cases, if a practitioner prescribes the monoproduct to a non-pregnant member because it is clinically indicated, the medication and visit will still be covered.
- Ensure medication for other physical and mental health conditions are provided as needed either on-site or through collaboration with other providers.
- Provide individualized, patient-centered assessment and treatment.
- Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the member; supervise withdrawal management from opioid analgesics, including methadone, buprenorphine products or naltrexone products; and oversee and facilitate access to appropriate treatment for opioid use disorder.
- Provide cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the member on an individual, group, or family basis.
- Provide optional substance use care coordination (G9012) that includes integrating behavioral health into primary care and specialty medical settings through

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interdisciplinary care planning and monitoring member progress and tracking member outcomes; supporting conversations between buprenorphine-waivered practitioners and behavioral health professionals to develop and monitor ISPs; linking members with community resources to facilitate referrals and respond to social service needs, or peer supports; and tracking and supporting members when they obtain medical, behavioral health, or social services outside the practice. Substance use care coordination cannot be provided simultaneously with substance use case management. CSBs/BHAs that are licensed as substance use case management providers should provide substance use case management services (H0006) instead of substance use case coordination.

- For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening for infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.
- Medication administration on site during the induction phase must be provided by a Registered Nurse (RN). Medication administration during the maintenance phase may be provided either by a RN or Licensed Practical Nurse (LPN).

OTP risk management shall include the following activities which must be clearly and adequately documented in each member's record:

- Random urine drug screening for all members, conducted at least eight times during a twelve month period as defined in 12VAC35-105-980.
- The Virginia Prescription Monitoring Program shall be checked at least quarterly for all members.
- Opioid overdose prevention education including the prescribing of naloxone.

To bill substance use care coordination (G9012), the OTP must document the following:

- Development and monitoring of the individualized and personalized OTP Interdisciplinary Plan of Care (IPOC) focused on the best outcomes for the member by the interdisciplinary treatment team (buprenorphine-waivered physician and credentialed addiction treatment professionals). Recommended IPOC template will be provided by DMAS. If provider chooses to use their own form, it must incorporate all elements from the DMAS IPOC template.
- Interdisciplinary care planning should consist of at least biweekly meetings of the interdisciplinary treatment team (including both medical and behavioral health professionals) to review the member's medical record (including urine drug screens and laboratory tests), discuss member progress in recovery, treatment team's progress in meeting the member's physical, behavioral health, and social needs, and reassessing Level of Care.

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- Monitoring member progress, tracking member outcomes, linking the member with community resources (including Alcoholics Anonymous, Narcotics Anonymous, peer recovery supports, etc.) to facilitate referrals and respond to social service needs.
- Tracking and supporting the member's medical, behavioral health, or social services received outside the practice.

Service Units and Limitations

- See ARTS Reimbursement Structure for billing codes and units for OTP services is available online: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.
- OTPs may be reimbursed for three separate inductions per 365 calendar days per member and must be at least 90 calendar days apart. The first day of each induction is billed using H0014. Additional physician visits within a 365 calendar day period shall be billed using the appropriate evaluation and management code. Thus providers would submit H0014 for day one of induction, and the appropriate evaluation and management code on day two and after. If a member fails three inductions within a 365 calendar day period in an OTP setting, the member should be referred to a higher level of care for assessment for treatment.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- Take home doses have a maximum 28 day limit (one month supply) dispensing at a time.
- OTP services do not require service authorization.

Office Based Opioid Treatment (OBOT)

Office-Based Opioid Treatment (OBOT), as defined in 12VAC30-130-5121, shall be provided by a buprenorphine-waivered practitioner and may be provided in a variety of practice settings including primary care clinics, outpatient health system clinics, psychiatry clinics, Federally-Qualified Health Centers (FQHCs), Community Service Boards(CSBs)/Behavioral Health Authorities (BHAs), local health department clinics, and physicians' offices. The practitioner shall be contracted and credentialed by the MCOs, MMPs and the BHSA to perform OBOT services. OBOT services shall meet the following service components and risk management criteria.

OBOT service components include the following activities. Providers must document the provision of the following activities, as rendered, in the member's medical record:

- Ensure access to emergency medical and psychiatric care.

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- Establish affiliations with more intensive levels of care such as intensive outpatient programs and partial hospitalization programs that unstable members can be referred to when clinically indicated.
- Provide individualized, patient-centered multidimensional assessment and treatment.
- Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the member; supervise withdrawal management from opioid analgesics; and oversee and facilitate access to appropriate treatment for opioid use disorder and alcohol use disorder.
- Ensure medication for other physical and mental illnesses are provided as needed either on-site or through collaboration with other providers.
- Ensure buprenorphine products are only dispensed on-site during the induction phase. After induction, buprenorphine products should be prescribed to the member.
- Ensure buprenorphine monoproducts are only prescribed in the following scenarios: when a patient is pregnant, when converting a patient from methadone or buprenorphine monoproduct to buprenorphine containing naloxone for a period not to exceed 7 days, or in formulations other than tablet form for indications approved by the FDA (pursuant to Board of Medicine regulations). All other members should be prescribed buprenorphine/naloxone or naltrexone products.
- The maximum daily buprenorphine or buprenorphine/naloxone dose should be 16 mg unless there is documentation of an ongoing compelling clinical rationale for a higher maintenance dose up to maximum of 24 mg.
- Due to a higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed (pursuant to Board of Medicine regulations).
- Provide cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, to the member on an individual, group, or family basis by credentialed addiction treatment professionals, practicing within the scope of their license, working in collaboration with the prescribing buprenorphine-waivered practitioner. The credentialed addiction treatment professional **must be co-located at the same practice site** and provide counseling when the buprenorphine-waivered practitioner is prescribing buprenorphine or naltrexone to members with moderate to severe opioid use disorder.
 - Community Service Boards(CSBs)/Behavioral Health Authorities (BHAs) and Federally-Qualified Health Centers are not required to have the credentialed addiction treatment professional co-located at the same practice site and providing

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counseling during clinic sessions when the buprenorphine-waivered practitioner is prescribing buprenorphine or naltrexone products to members with opioid use disorder. The credentialed addiction treatment professional must be employed by the same organization and providing counseling to members prescribed buprenorphine or naltrexone products. They must engage in interdisciplinary care planning with the buprenorphine-waivered practitioner including working together to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the member.

- Counseling can be provided via telemedicine in rural areas if the nearest credentialed addiction treatment professional is located more than 60 miles away from the buprenorphine-waivered practitioner. The credentialed addiction treatment professional must develop a shared care plan with the buprenorphine-waivered practitioner and the member and take extra steps to ensure that substance use care coordination and interdisciplinary care planning are occurring.
- To bill substance use care coordination (G9012), the OBOT must document the following:
 - Development and monitoring of the individualized and personalized OBOT Interdisciplinary Plan of Care (IPOC) focused on the best outcomes for the member by the interdisciplinary treatment team (buprenorphine-waivered physician and credentialed addiction treatment professionals). DMAS is developing a recommended IPOC template for OBOTs which will be provided at a later date. Until this template is developed, providers should include the elements of the ISP as noted in this chapter in the member's record.
 - Interdisciplinary care planning should consist of at least biweekly meetings of the interdisciplinary treatment team (including both medical and behavioral health professionals) to review the member's medical record (including urine drug screens and laboratory tests), discuss member progress in recovery, treatment team's progress in meeting the member's physical, behavioral health, and social needs, and reassessing Level of Care.
 - Monitoring member progress, tracking member outcomes, linking the member with community resources (including Alcoholics Anonymous, Narcotics Anonymous, peer recovery supports, etc.) to facilitate referrals and respond to social service needs.
 - Tracking and supporting the member's medical, behavioral health, or social services received outside the practice.
- Substance use care coordination cannot be provided simultaneously with substance use case management. CSBs/BHAs who are licensed as substance use case management providers should provide substance use case management services (H0006) instead of substance use case coordination.

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- For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening for infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.
- Medication administration on site during the induction phase must be provided by a Registered Nurse (RN).

OBOT risk management shall include the following activities which shall be documented in each member's record:

- Routine and/or random urine drug screens, conducted a minimum of 8 times per year for all members with at least some tests unannounced or random.
- Virginia Prescription Monitoring Program checked at least quarterly for all members.
- Opioid overdose prevention education including the prescribing of naloxone for all members.
- Members must be seen at least weekly by the buprenorphine-waivered practitioner or credentialed addiction treatment professional during the first three months when initiating treatment. Member must have been seen for at least 3 months with documented clinical stability before spacing out to a minimum of monthly visits with buprenorphine-waivered practitioner or credentialed addiction treatment professional. The IPOC must be updated to reflect these changes.
- Periodic monitoring of unused medication and opened medication wrapper counts when clinically indicated.

Home Inductions in OBOT Setting

Buprenorphine waived practitioners may consider home induction for members if it is determined by the practitioner to be feasible and safe. This may be if the practitioner has previously treatment a returning member, has conducted an observed induction with this member and trusts that he/she has history of responsible use of the medication. If a buprenorphine waived practitioner decides to pursue this strategy, DMAS recommends using after member education is provided, in previously treated members who are known to be reliable, or for members who demonstrate clear documented knowledge of the risks of unobserved induction and are willing to come to the office in the event of problems. Members should be provided with explicit written instructions regarding the subjective and objective assessment of opioid withdrawal, the timing and dose of buprenorphine, and phone numbers for assistance. The buprenorphine waived practitioner shall maintain close telephone contact with the member during the unobserved induction. The practitioner shall review with the member steps to access emergency medical and psychiatric care clinic hours if needed.

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Providers must follow the same protocol for office based inductions as stated above (the section in manual that incorporates the OBOT Credentialing Checklist requirements) and the member must receive the cognitive, behavioral, and other substance use disorder focused therapy at the practitioners office on the days the members comes for the office visit.

Service Units and Limitations

- See ARTS Reimbursement Structure for billing codes and units for OBOT services is available online: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.
- OBOTs may be reimbursed for three separate inductions per 365 calendar days per member and must be at least 90 calendar days apart. The first day of each separate induction is billed using H0014. Additional physician/nurse practitioner/physician assistant follow up and maintenance visits within a 365 calendar day period shall be billed using the appropriate evaluation and management code. Thus providers would submit H0014 for day one of induction, and the appropriate evaluation and management code on day two and after. If a member fails three buprenorphine or buprenorphine/naloxone inductions within a 365 calendar day period in an OBOT setting, the member should be referred to an OTP for assessment for treatment.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- OBOT services do not require service authorization.

Substance Use Case Management

Substance use case management services assist members and their family members in accessing needed medical, psychiatric, psychological, social, educational, vocational, recovery, and other supports essential to meeting the member's basic needs. Substance use case management services are to be person-centered, individualized, culturally and linguistically appropriate to meet the member's and family member's needs. The Medicaid eligible member shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria for substance use disorder. Tobacco-related disorders, caffeine related disorders and non-substance-related disorders shall not be covered. If a member has co-occurring mental health and substance use disorders, the case manager shall include activities to address both the mental health and substance use disorders.

Substance use case management shall include an active individual service plan (ISP) which requires a minimum of two substance use case management service activities each month, and at least one face-to-face contact with the member at least every 90 calendar days. Substance use case management is reimbursable on a monthly basis only when the minimum substance use case management service activities are met as noted later in this section. Only one type of case management may be billed at one time. Please see the Limitations section. Substance use case

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management can be provided as a stand-alone service, without the condition that the member shall be receiving another Medicaid covered service, including Medicaid-covered ARTS service.

Substance use case management services are intended to be an individualized person-specific activity between the case manager and the member. There are some appropriate instances where the case manager could offer case management to more than one member at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more members was person-specific. For example, the case manager needs to work with two members, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both members simultaneously for the purpose of helping each member obtain a financial entitlement and subsequently follow-up with each member to ensure he or she has proceeded correctly.

Substance Use Case Management Service Activities

Substance use case management service activities include the following:

1. Assessing needs and planning services to include developing a substance use case management ISP developed with the member, in consultation with the member's family, as appropriate as defined in 12VAC30-130-5020. The ISP shall utilize accepted placement criteria and shall be fully completed within 30 calendar days of initiation of service.
2. Enhancing community integration through increased opportunities for community access and involvement and enhancing community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
3. Making collateral contacts with the member's significant others with properly authorized releases to promote implementation of the member's ISP and his community adjustment;
4. Linking the member to those community supports that are most likely to promote the personal habilitative or rehabilitative, recovery, and life goals of the member as developed in the ISP;
5. Assisting the member directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;
6. Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.
7. Monitoring service delivery through contacts with members receiving services and service providers including site and home visits to assess the quality of care and satisfaction of the member;

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8. Providing follow-up instruction, education, and counseling to guide the member and develop a supportive relationship that promotes the ISP;
9. Advocating for members in response to their changing needs, based on changes in the ISP;
10. Planning for transitions in the member's life;
11. Knowing and monitoring the member's health status, any medical conditions, medications and potential side effects, and assisting the member in accessing primary care and other medical services, as needed; and
12. Understanding the capabilities of services to meet the member's identified needs and preferences and to serve the member without placing the member, other participants, or staff at risk of serious harm.

Service Units and Limitations

- The billing unit for case management is per month.
- Substance use case management services are not reimbursable for members while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.
- No other type of case management may be billed concurrently with substance abuse case management including mental health, treatment foster care, or services that include case management activities such as Intensive Community Treatment.
- Substance use case management may not be billed concurrently with substance use care coordination.
- Substance use case management does not include maintaining service waiting lists or periodically contacting or tracking members to determine potential service needs that do not meet the requirements for the monthly billing.
- Substance use case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible member has been referred.
- Substance use case management does not include activities for which an member may be eligible, that are integral to the administration of another nonmedical program, except for case management that is included in an individualized education program or individualized family service plan consistent with § 1903(c) of the Social Security Act.

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Outpatient Services (ASAM Level 1)

Outpatient services (ASAM Level 1) as defined in 12VAC30-130-5080 shall be provided by a credentialed addiction treatment professional, psychiatrist, or physician contracted by the MCOs, MMPs and the BHSA to perform these services in the following community based settings: primary care clinics, outpatient health system clinics, psychiatry clinics, Federally Qualified Health Centers (FQHCs), Community Service Boards (CSBs)/Behavioral Health Authorities (BHSs), local health departments, physician and provider offices in private or group practices.

Reimbursement for substance use outpatient services shall be made for medically necessary services provided in accordance with an ISP or the treatment plan and include withdrawal management as necessary. Services can be provided face-to-face or by telemedicine according to DMAS policy regarding telemedicine.

Outpatient services (ASAM Level 1) shall include the following service components as medically necessary and indicated in the member's ISP:

- Professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.
- An ISP as defined earlier in this Chapter shall be used and documented to determine that an member meets the medical necessity criteria and shall include the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services.
- A physical examination and laboratory testing as necessary for substance use disorder treatment. For members who have not been screened for infectious diseases within previous 12 months, screening on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.
- Member counseling between the member and a credentialed addiction treatment professional. Services provided face-to-face or by telemedicine shall qualify as reimbursable.
- Group counseling by a credentialed addiction treatment professional, with a maximum of 10 members in the group. Such counseling shall focus on the needs of the members served.
- Family therapy to facilitate the members' recovery and support for the family's recovery provided by a credentialed addiction treatment professional.
- Evidenced-based member education on addiction, treatment, recovery and associated health risks.

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- Medication services including the prescription of or administration of medication related to substance use treatment, or the assessment of the side effects or results of that medication. Medication services shall be provided by staff lawfully authorized to provide such services and they shall order laboratory testing within their scope of practice or licensure.
- Collateral services as defined under the definition section in the beginning of this chapter.
- To ensure continuity of care, members who are transitioning to Level 1.0 from a higher Level of Care, the initial outpatient appointment should be provided within 7 business days of discharge.
- These services may be provided on site or through referral to an outside provider.

Co-Occurring Enhanced Programs

In addition to all of the above, outpatient services (ASAM Level 1) co-occurring enhanced programs shall include:

- Ongoing substance use case management for highly crisis prone members with co-occurring disorders. Outpatient service providers may coordinate the substance use case management services with the DBHDS licensed substance use case management provider.
- Credentialed addiction treatment professionals who are trained in severe and chronic mental health and psychiatric disorders and are able to assess, monitor and manage members who have a co-occurring mental health disorder.

Service Units and Limitations

- See ARTS Reimbursement Structure for billing codes and units for outpatient services: is available online: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.
- Substance use outpatient services shall be provided fewer than 9 hours per week.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- Outpatient substance use disorder treatment services do not require service authorization.
- Opioid Treatment Services/Medication Assisted Treatment including medications, labs, and urine drug screens may be billed separately in community-based settings.

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Intensive Outpatient Services (ASAM Level 2.1)

Intensive outpatient services (ASAM Level 2.1) as defined in 12VAC30-130-5090 are structured program of skilled treatment services for adults, children and adolescents delivering a minimum of 3 service hours per service day to achieve 9 to 19 hours of services per week for adults and 6 to 19 hours of services per week for children and adolescents. This service is provided to members who do not require the intensive level of care of inpatient, residential, or partial hospitalization services, but require more intensive services than outpatient services.

Intensive outpatient service providers shall meet the ASAM Level 2.1 service components. The following service components shall be assessed and monitored weekly and shall be provided in accordance to the ASAM Criteria, as directed by the member's ISP and based on the member's treatment needs identified in the multidimensional assessment. The provider must demonstrate the ability to provide or access through referral, as appropriate to meet the objectives in the member's ISP, the following service components:

- Psychiatric and other individualized treatment planning.
- Individual, family and/or group psychotherapy.
- Medication management and psychoeducational activities.
- Requests for a psychiatric or a medical consultation shall be available within 24 hours of the requested consult by telephone and preferably within 72 hours of the requested consult in person or via telemedicine. Referrals to external resources are allowed in this setting.
- Psycho-pharmacological consultation.
- Addiction medication management provided on-site or through referral.
- 24-hour emergency services available.
- Occupational and recreational therapies, motivational interviewing, enhancement, and engagement strategies to inspire a member's motivation to change behaviors.
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral, as indicated in the member's ISP. For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Withdrawal management services may be provided as necessary by qualified staff either on site or through referral. Providers should refer to the ASAM Criteria text for Intoxication/Withdrawal Management guidelines.

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Co-Occurring Enhanced Programs

In addition to the above, Intensive Outpatient Services (ASAM Level 2.1) co-occurring enhanced programs offer these therapies and support systems in intensive outpatient services described above to members with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a planned program of therapies. Members who are not able to benefit from a full program of therapies, will be offered and provided services or a referral made to enhanced program services to match the intensity of hours in ASAM Level 2.1, including substance use case management, intensive community treatment, medication management and psychotherapy.

Service Units and Limitations

- Intensive outpatient services require service authorization. The MCOs, MMPs and the BHSA will respond within 3 calendar days to the service authorization request. If approved, the MCOs, MMPs, and BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.
- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge, the member ceases to participate.
- Intensive Outpatient services may be provided concurrently with Opioid Treatment Services. Collaboration between the Intensive Outpatient provider and the buprenorphine-waivered practitioner is required.
- Opioid Treatment Services/Medication Assisted Treatment including physician visits and medications, labs, and urine drug screens may be billed separately.
- Staff travel time is excluded.
- One unit of service is one day with a minimum of 3 service hours per service day to achieve 9 to 19 hours of services per week for adults and 6 to 19 hours of services per week for children and adolescents, with regards to the first and last week of treatment. Maximum of 19 hours shall be billed per week. In cases that a member does not complete the minimum of 3 service hours per service day, the provider should document any deviation from the ISP in the member's medical record and reason for the deviation and notify the MCO/MMP/BHSA weekly when the minimum sessions have not been provided. If the member consistently deviates from the required services in the ISP, the provider should work with the MCO/MMP/BHSA ARTS Care Coordinator to reassess for another ASAM Level of Care or model to better meet the member's needs.
- ASAM Criteria allows of less than 9 hours per week for adults and 6 hours per week for adolescents as a transition step down in intensity for 1 to 2 weeks prior to transitioning to Level 1 to avoid relapse. The transition step down needs to be approved by the MCO/MMP/BHSA and documented and supported by the member's ISP.

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- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- There are no maximum annual limits.

Partial Hospitalization Services (ASAM Level 2.5)

Substance use partial hospitalization services (ASAM Level 2.5) as defined in 12VAC30-130-5100, are structured program of skilled treatment services for adults, children and adolescents delivering. The minimum number of service hours per week is 20 hours with at least five service hours per service day of skilled treatment services.

Partial hospitalization (ASAM Level 2.5) service components shall include the following provided at least once weekly or as directed by the ISP and based on the member's treatment needs identified in the multidimensional assessment:

- Individualized treatment planning;
- Withdrawal management services may be provided as necessary. Providers should refer to the ASAM Criteria text for Intoxication/Withdrawal Management guidelines.
- Family therapies involving family members, guardians, or significant other in the assessment, treatment, and continuing care of the member;
- Motivational interviewing, enhancement, and engagement strategies;
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available by consult or referral;
- For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation;
- Psychiatric and medical formal agreements to provide medical consult within 8 hours of the requested consult by telephone, or within 48 hours in person or via telemedicine. Referrals to external resources are allowed in this setting;
- Emergency services available 24-hours a day and seven days a week;
- Close coordination through referrals to higher and lower levels of care and supportive housing services such as in a Clinically Managed Low Intensity Residential Services (ASAM Level 3.1).

The following service components shall be provided a minimum of once each day the member is in attendance or more as the treatment needs identified in the multidimensional assessment require.

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- Skilled treatment services with a planned format including member and group psychotherapy.
- Medication management.
- Education groups.
- Occupational, recreational therapy, and/or other therapies.

Co-Occurring Enhanced Programs

In addition to the above, Partial Hospitalization Services (ASAM Level 2.5) co-occurring enhanced programs shall offer the following:

- Therapies and support systems as described above to members with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a full program of therapies. Other members who are not able to benefit from a full program of therapies (who are severely or chronically mentally ill) will be offered/referred/linked to enhanced program services to constitute intensity of hours in Level 2.5, including substance use case management, intensive community treatment, medication management, and psychotherapy.
- Psychiatric services as appropriate to meet the member's mental health condition. Services may be available by telephone and on site, or closely coordinated off site, or via telemedicine.
- Clinical leadership and oversight and, at a minimum, capacity to consult with an addiction psychiatrist via telephone, telemedicine, or in person.
- Credentialed addiction treatment professionals with experience assessing and treating co-occurring mental illness.

Service Units and Limitations

- Partial Hospitalization services require service authorization. The MCOs, MMPs and the BHSA will respond within 3 calendar days to the service authorization request. If approved, the MCOs, MMPs, and BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.
- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge, or the member ceases to participate.
- Partial Hospitalization services may be provided concurrently with Opioid Treatment Services/Medication Assisted Treatment. Collaboration between the Partial Hospitalization provider and the buprenorphine-waivered practitioner is required.
- Opioid Treatment Services/Medication Assisted Treatment including physician visits and medications, labs, and urine drug screens may be billed separately.

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- Staff travel time is excluded.
- One unit of service is one day and the minimum number of service hours per week is 20 hours with at least five service hours per service day of skilled treatment services, with regards to the first and last week of treatment. In cases that a member does not complete the minimum of 5 clinical service hours per service day, the provider should document any deviation from the ISP in the member's medical record and reason for the deviation and notify the MCO/MMP/BHSA weekly when the minimum sessions have not been provided. If the member consistently deviates from the required services in the ISP, the provider should work with the MCO/MMP/BHSA ARTS Care Coordinator to reassess for another ASAM Level of Care or model to better meet the member's needs. Medicaid allows as a transition step down in intensity for 1 to 2 weeks prior to transitioning to Level 2.1 or 1 to avoid relapse. The transition step down needs to be approved by the MCO/MMP/BHSA and documented and supported by the member's ISP.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- There are no maximum annual limits.

Clinically Managed Low Intensity Residential Services (ASAM Level 3.1)

Clinically managed low intensity residential services (ASAM Level 3.1) as defined in 12VAC30-130-5110 providing a minimum of at least five hours of clinically directed program activities per week shall be provided. This service shall not include settings such as sober houses, boarding houses or group homes where treatment services are not provided.

Clinically managed low intensity residential services (ASAM Level 3.1) required service components include:

- A face-to-face multidimensional assessment performed upon admission by a credentialed addiction treatment professional acting within scope of their practice, who shall determine and document a DSM5/ICD-10 diagnosis.
- Initial ISP within 24 hours & Comprehensive Individualized Service Plan (ISP) within 15 days
- Services for the member's family and significant others, as appropriate to advance the member's treatment goals and objectives identified in the ISP.
- Weekly face to face meetings with the member and the treatment team will be required to review, discuss and document treatment progress and progress toward discharge. A week is defined as Sunday through Saturday.

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- Clinically directed program activities by credentialed addiction treatment professionals, constituting at least five hours per week of professionally directed treatment designed to stabilize and maintain substance use disorder symptoms, and to develop and apply recovery skills, utilizing motivational enhancement and engagement strategies.
- Counseling and clinical monitoring to support initial or re-involvement in regular productive daily activity and reintegration into family or community living with health education.
- Relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery. Services shall promote personal responsibility and re-integration of the member into the network systems of work, education, and family and community life.
- Physician consultation and emergency services, which shall be available 24 hours a day and seven days per week.
- Arrangements for medically necessary procedures including laboratory and toxicology tests, which are appropriate to the severity and urgency of a member's condition.
- Arrangements for pharmacotherapy for psychiatric or anti-addiction medications and drug screenings.
- Arrangements for higher and lower levels of care and other services. Direct affiliations or close coordination through referral to more and less intensive levels of care and other services such as intensive outpatient, vocational assessment and placement, literacy training, and adult education.
- Regular monitoring of the member's medication adherence.
- Education on benefits and potential side effects of medication assisted treatment and referral to treatment as necessary. Opportunities for member to be introduced to the potential benefits of addiction pharmacotherapies as a long term tool to manage addiction.
- Biomedical enhanced services are delivered by appropriately credentialed medical staff who are available to assess and treat co-occurring biomedical disorders and to monitor the member's administration of medications in accordance with a physician's prescription.
- Coordination with community physicians to review treatment as needed.
- Appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the member's scheduled discharge date.
- Follow-up and monitoring of members immediately after discharge to ensure continuity of engagement.

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Co-Occurring Enhanced Programs

In addition to the Level 3.1 service components listed in this section, Clinically Managed Low Intensity Residential Services (ASAM Level 3.1) co-occurring enhanced programs shall offer the following:

- Programs for members who have both unstable substance use and psychiatric disorders including appropriate psychiatric services, medication evaluation and laboratory services. Such services are provided either on-site, via telemedicine, or closely coordinated with an off-site provider, as appropriate to the severity and urgency of the member's mental health condition. In addition to the Level 3.1 support systems listed above, Level 3.1 co-occurring enhanced programs offer appropriate psychiatric services, including medication evaluation and laboratory services. Such services are provided on-site or closely coordinated off-site, as appropriate to the severity and urgency of the member's mental condition.
- Level 3.1 co-occurring capable programs must offer the therapies described above as well as planned clinical activities (either directly or through affiliated providers) that are designed to stabilize the member's mental health program and psychiatric symptoms and to maintain such stabilization. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental illness.

Discharge planning

Beginning at admission and continuing throughout the member's placement, the member or legally authorized representative and either the MCO or BHSA ARTS Care Coordinator shall be involved in treatment planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. At least 15 calendar days prior to discharge, the provider shall submit an active discharge plan to the MCO, MMP or the BHSA for review. Once the MCO, MMP or the BHSA approves the discharge plan, the provider shall begin collaborating with the member or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments as needed. The provider shall request written permission from the member or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The provider shall request information from post-discharge providers to establish that the planning of services and activities has begun. The provider shall inform the MCO, MMP or the BHSA of all scheduled appointments within 7 calendar days prior to discharge, and shall notify the MCO, MMP or the BHSA within one business day of the member's discharge date from their facility.

Service Units and Limitations

- ASAM Level 3.1 services require service authorization. The MCOs, MMPs and the BHSA will respond within 1 calendar day to the service authorization request. If

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approved, the MCOs, MMPs, and BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.

- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge or the member moves out of the facility.
- ASAM Level 3.1 services may be provided concurrently with opioid treatment services/medication assisted treatment, partial hospitalization services, intensive outpatient services and outpatient services.
- Opioid Treatment Services/Medication Assisted Treatment including medications, labs, and urine drug screens may be billed separately in community-based settings.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- Staff travel time is excluded.
- Medicaid does not pay for room and board.
- One unit of service is one day.
- There are no maximum annual limits.

Clinically Managed Population-Specific High Intensity Residential Service (ASAM Level 3.3)

Clinically managed population-specific high intensity residential services (ASAM Level 3.3) as defined in 12VAC30-130-5120, must have service components which include:

- Access to consulting physician or physician extender and emergency services 24 hours a day and seven days a week via telephone and in person.
- Arrangements for higher and lower levels of care, including direct affiliations or close coordination through referral to more and less intensive levels of care and other services such as Intensive Outpatient Services (IOP), vocational assessment and placement, literacy training, and adult education.
- Arrangements for laboratory and toxicology services appropriate to the severity of need. Arrangements for addiction pharmacotherapy including pharmacotherapy for psychiatric or anti-addiction medications including drug screenings. For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Regular monitoring of the member's medication adherence.

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- Weekly face to face meetings with the member and the treatment team or credentialed addiction treatment professional who prepared the ISP will be required to document treatment progress and progress toward discharge.
- Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the member into the network systems of work, education, and family life. Daily clinical services shall be provided to improve organization, daily living skills, recovery, personal responsibility, personal appearance and punctuality.
- Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the member in initial involvement or re-engagement in regular productive daily activity.
- Recreational therapy, art, music, physical therapy and vocational rehabilitation. These services do not constitute the primary mode of treatment.
- Clinical and didactical motivational interventions to address readiness to change and understanding of disorder life impacts.
- Recovery support services.
- Services for the member's family and significant others, as appropriate to advance the member's treatment goals and objectives identified in the ISP.
- Education on benefits of medication assisted treatment and referral to treatment as necessary.
- Withdrawal management services may be provided as necessary. Providers should refer to the ASAM Criteria for Intoxication/Withdrawal Management guidelines.
- Substance use case management is included in this level of care. Substance use case management services (H0006) are not reimbursable for members while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.

Co-Occurring Enhanced Programs

Clinically managed population-specific high intensity residential service co-occurring enhanced programs, programs shall include the Level 3.3 service components listed in this section, including appropriate psychiatric services, medication evaluation and laboratory services which shall be provided on-site or through a closely coordinated off-site provider, as appropriate to the severity and urgency of the member's mental condition. Level 3.3 co-occurring enhanced programs offer planned clinical activities designed to stabilize the member's mental health programs and psychiatric symptoms, and to maintain stabilization

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Therapeutic Passes

Therapeutic passes mean time away from the treatment facility with identified goals as clinically indicated by the treating credential addiction treatment professional and documented in the ISP. Therapeutic passes are paired with community and facility-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement. Therapeutic leave passes of 24 hours or more, or 2 consecutive days of passes 8 hours or more shall require service authorization. Providers shall consult with the MCO, MMP or BHSA regarding the service authorization process for therapeutic passes. Any unauthorized therapeutic passes shall result in retraction for those days of service.

Discharge planning

Beginning at admission and continuing throughout the member's placement, the member or legally authorized representative and either the MCO, MMP or BHSA ARTS Care Coordinator shall be involved in treatment planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. At least 7 calendar days prior to discharge, the provider shall submit an active discharge plan to the MCO, MMP or the BHSA for review. Once the MCO, MMP or the BHSA approves the discharge plan, the provider shall begin collaborating with the member or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments as needed. The provider shall request written permission from the member or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The provider shall request information from post-discharge providers to establish that the planning of services and activities has begun. The provider shall inform the MCO, MMP or the BHSA of all scheduled appointments prior to discharge, and shall notify the MCO, MMP or the BHSA within one business day of the member's discharge date from their facility.

Service Units and Limitations

- ASAM Level 3.3 requires service authorization. The MCOs, MMPs and the BHSA will respond within 1 calendar day to the service authorization request. If approved, the MCOs, MMPs, and BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.
- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge, or the member discontinues services.
- ASAM Level 3.3 services may be provided concurrently with Opioid Treatment Services.
- Opioid Treatment Services/Medication Assisted Treatment including medications, labs, and urine drug screens may be billed separately in community-based settings.
- One unit of service is one day.

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- There are no maximum annual limits but shall meet ASAM Criteria.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- Providers may not bill another payer source for any supervisory services; daily supervision, including one-on-one, is included in the Medicaid per diem reimbursement.
- Residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.
- FAMIS/FAMIS MOMS/GAP benefits do not cover residential treatment services.
- Some examples of non-reimbursable services include:
 - Remedial education (tutoring, mentoring)
 - Evaluation for educational placement or long-term placement
 - Day care
 - Psychological testing for educational diagnosis, school, or institutional admission and/or placement
 - Partial hospitalization programs/ Intensive Outpatient Programs
 - Case management for therapy services
 - Team meetings

Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium-Intensity Residential Services (Adolescent) (ASAM Level 3.5)

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) as defined in 12VAC30-130-5130, are residential treatment services which shall include:

- Telephone or in-person consultation with a physician or physician-extender who shall be available to perform required physician services. Emergency services shall be available 24 hours per day and seven days per week.
- Arrangements for more and less intensive levels of care and other services such as sheltered workshops, literacy training, and adult education.
- Arrangements for needed procedures including medical, psychiatric, psychological, lab and toxicology services appropriate to the severity of need. For members who have not been screened for infectious diseases within previous 12 months, screening provided on-

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site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.

- Arrangements for addiction pharmacotherapy.
- Random drug screening to monitor and reinforce recovery.
- Clinically directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the member into the network systems of work, education, and family life.
- Program activities shall be designed to stabilize and maintain substance use disorder symptoms and apply recovery skills and may include relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery.
- Daily clinical services to improve organization, daily living skills, recovery, personal responsibility, personal appearance and punctuality. Development and practice of prosocial behaviors.
- Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the member in initial involvement or re-engagement in regular productive daily activities including education on medication management, addiction pharmacotherapy, and education skill building groups to enhance the member's understanding of substance use and mental illness.
- Clinically directed program activities designed to stabilize and maintain substance use disorder symptoms, and apply recovery skills. Relapse prevention, interpersonal choice exploration, development of social networks in support of recovery.
- Counseling and clinical interventions to facilitate teaching the member skills needed for productive living and successful reintegration into family living to include health education.
- Monitoring of the adherence to prescribed medications and over-the-counter medications and supplements.
- Daily treatments to manage acute symptoms of biomedical substance use or mental health disorder
- Planned clinical interventions to enhance the members understanding of substance use and mental health disorders.
- Daily scheduled professional services, interdisciplinary assessments and treatment, designed to develop and apply recovery skills, including relapse prevention, interpersonal choices, and development of social network supportive of recovery. Such services would include member and group counseling, psychotherapy, family therapy, recreational therapy, art, music, physical therapy, vocational rehabilitation, educational and skill building groups,

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- Planned community reinforcement designed to foster improved community living skills.
- Motivational enhancements and engagement strategies appropriate to the members' stage of readiness and desire to change.
- Counseling and clinical monitoring assist the member in initial involvement or re-involvement in regular productive daily activity such as work or school, with successful re-integration into family living with health education.
- Services for family and significant others, as appropriate, to advance the member's treatment goals and objectives identified in the ISP.
- Education on benefits of medication assisted treatment and referral to treatment as necessary.
- Withdrawal management services may be provided as necessary. Providers should consult the ASAM Criteria for Intoxication/Withdrawal Management requirements.
- Substance use case management is included in this level of care. Substance use case management services (H0006) are not reimbursable for members while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.

Co-Occurring Enhanced Programs

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) co-occurring enhanced programs shall include the services listed in this section in addition to psychiatric services (psychiatric evaluation and/or therapy individual, group, family), medication evaluation, and laboratory services which shall be available by telephone within eight hours of requested service and on-site or via telemedicine, or closely coordinated with an off-site provider within 24 hours of requested service, as appropriate to the severity and urgency of the member's mental and physical condition. Level 3.5 co-occurring enhanced programs offer planned clinical activities designed to stabilize the member's mental health problems and psychiatric symptoms, and to maintain such stabilization. Planned clinical activities shall be required and shall be designed to stabilize and maintain the member's mental health problems and psychiatric symptoms.

Family engagement shall be provided in addition to family therapy/counseling as appropriate. Family engagement shall be provided as outlined in the ISP and the family or legally authorized representative shall be part of the family engagement strategies in the ISP. Family engagement activities are considered to be an intervention and shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Interventions shall be documented on a progress note and shall be outlined in and aligned with

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the treatment goals and objectives in the ISP. Any deviation from the ISP shall be documented along with a clinical or medical justification for the deviation based on the needs of the member.

Therapeutic Passes

Therapeutic passes mean time away from the treatment facility with identified goals as clinically indicated by the treating credential addiction treatment professional and documented in the ISP. Therapeutic passes are paired with community and facility-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement. Therapeutic leave passes of 24 hours or more, or 2 consecutive days of passes 8 hours or more shall require service authorization. Providers shall consult with the MCO, MMP or BHSA regarding the service authorization process for therapeutic passes. Any unauthorized therapeutic passes shall result in retraction for those days of service.

Discharge planning

Beginning at admission and continuing throughout the member's placement, the member or legally authorized representative and either the MCO, MMP or BHSA ARTS Care Coordinator shall be involved in treatment planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. At least 7 calendar days prior to discharge, the provider shall submit an active discharge plan to the MCO, MMP or the BHSA for review. Once the MCO, MMP or the BHSA approves the discharge plan, the provider shall begin collaborating with the member or legally authorized representative and the treatment team to prepare the member for referral into another level of care, post treatment return or reentry into the community, or the linkage of the member to essential community treatment, housing, recovery, and human services. The provider shall request written permission from the member or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The provider shall request information from post-discharge providers to establish that the planning of services and activities has begun. The provider shall inform the MCO, MMP or the BHSA of all scheduled appointments within 7 calendar days of discharge, and shall notify the MCO, MMP or the BHSA within one business day of the member's discharge date from their facility.

Service Units and Limitations

- ASAM Level 3.5 requires service authorization. The MCOs, MMPs and the BHSA will respond within 1 calendar day to the service authorization request. If approved, the MCOs, MMPs, and BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.
- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge or the member leaves the facility.
- ASAM Level 3.5 services may be provided concurrently with opioid treatment services.

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- Opioid Treatment Services/Medication Assisted Treatment including medications, labs, and urine drug screens may be billed separately in community-based settings.
- One unit of service is one day.
- There are no maximum annual limits.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- Providers may not bill another payer source for any supervisory services; daily supervision, including one-on-one, is included in the Medicaid per diem reimbursement.
- Residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.
- FAMIS/FAMIS MOMS/GAP do not cover residential treatment services.
- Some examples of non-reimbursable services include:
 - Remedial education (tutoring, mentoring)
 - Evaluation for educational placement or long-term placement
 - Day care
 - Psychological testing for educational diagnosis, school, or institutional admission and/or placement
 - Partial hospitalization programs / Intensive Outpatient Programs
 - Case management for therapy services
 - Team meetings

Medically Monitored Intensive Inpatient Services (Adult) and Medically Monitored High Intensity Inpatient Services (Adolescent) (ASAM Level 3.7)

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) as defined in 12VAC30-130-5140, and shall meet the following service components:

- Clinical staff shall be able to provide a planned regimen of 24 hour professionally directed evaluation, care and treatment including the administration of prescribed medications.
- Addiction-credentialed physician or physician with experience in addiction medicine shall oversee the treatment process and assure quality of care. Licensed physicians or

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physician extenders shall perform physical examinations for all members who are admitted; except in cases where a member is admitted to Level 3.7 as a step-down from Level 4.0 within the same facility, in which case the physician/physician extender shall review the physical exam that was performed within the previous 7 days. Staff shall supervise addiction pharmacotherapy, integrated with psychosocial therapies. The professional may be a physician or psychiatrist, or physician extender as defined in 12VAC30-130-5020 if knowledgeable about addiction treatment. Physician monitoring, nursing care and observation shall be available. A physician shall assess the member in person within 24 hours of admission and thereafter as medically necessary.

- A registered nurse (RN) under direction of either a Physician Medical Director, shall conduct an alcohol or other drug focused nursing assessment upon admission. The RN shall have the competencies and experience in conducting an alcohol or other drug focused nursing assessment. The RN performing the alcohol or other drug focused nursing assessment shall report the results to the attending physician, who then directs initiation of the medical-monitored protocol based on the results of the focused assessment. A RN or licensed practical nurse (LPN) shall be responsible for monitoring the member's progress and for medication administration duties.
- Daily clinical services provided by an interdisciplinary team to involve appropriate medical and nursing services, as well as individual, group and family therapy services. Activities may include pharmacological, withdrawal management, cognitive-behavioral, and other therapies administered on an individual or group basis and modified to meet the member's level of understanding and assist in the member's recovery.
- Planned clinical activities to enhance understanding of substance use disorders. Planned clinical program activities to stabilize acute addictive or psychiatric symptoms. Activities may include pharmacological, cognitive-behavioral, and other therapies administered on an individual or group basis and adapted to the member's level of comprehension.
- Counseling and clinical monitoring to facilitate re-involvement in regular productive daily activities and successful re-integration into family living if applicable. Counseling and clinical monitoring to promote re-involvement in or skill building in regular productive daily activities such as work or school and successful re-integration into family living if applicable.
- Random drug screens to monitor use and strengthen recovery and treatment gains.
- Regular medication monitoring.
- Health education associated with the course of addiction and other potential health related risk factors including Tuberculosis, HIV, Hepatitis B and C, and other sexually transmitted Infections.

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- Evidence based practices such as motivational interviewing to address the members readiness to change, designed to facilitate understanding of the relationship of the substance use disorder and life impacts.
- Daily treatments to manage acute biomedical symptoms of substance use or mental illness.
- Services to family and significant others as appropriate to advance the member's treatment goals and objectives identified in the ISP.
- Additional medical specialty consultation, psychological, laboratory and toxicology services shall be available on site, either through consultation or referral. For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Coordination of necessary services shall be available on-site or through referral to a closely coordinated off-site provider to transition the member to lower levels of care. Substance use case management is included in this level of care. Substance use case management services (H0006) are not reimbursable for members while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.
- Psychiatric services are available onsite, through consultation or referral when a presenting problem could be attended to at a later time. Such services are available within 8 hours by telephone and 24 hours in-person.
- Medication education and management shall be offered.

Co-Occurring Enhanced Programs

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) co-occurring enhanced programs shall include the services listed in this section in addition to appropriate psychiatric services, medication evaluation, and laboratory services. A psychiatric assessment of the member shall occur within 4 hours of admission by telephone and within 24 hours following admission in person or via telemedicine, or sooner, as appropriate to the member's behavioral health condition, and thereafter as medically necessary. A behavioral health-focused assessment at the time of admission shall be performed by a registered nurse or licensed mental health clinician. A licensed registered nurse or licensed practical nurse supervised by a registered nurse shall be responsible for monitoring the member's progress and administering or monitoring the member's self-administration of medications.

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Planned clinical activities shall be offered and designed to promote stabilization and maintenance of the member's behavioral health needs, recovery, and psychiatric symptoms. Evidence based practices such as motivational enhancement strategies and interventions appropriate to address the members readiness to change, designed to facilitate understanding of relationship of the substance use disorder and life impacts.

Therapeutic Passes

Therapeutic passes mean time away from the treatment facility with identified goals as clinically indicated by the treating credential addiction treatment professional and documented in the ISP. Therapeutic passes are paired with community and facility-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement. Therapeutic leave passes of 24 hours or more, or 2 consecutive days of passes 8 hours or more shall require service authorization. Providers shall consult with the MCO, MMP or BHSA regarding the service authorization process for therapeutic passes. Any unauthorized therapeutic passes shall result in retraction for those days of service.

Discharge planning

Beginning at admission and continuing throughout the member's placement, the member or legally authorized representative and either the MCO, MMP or BHSA ARTS Care Coordinator shall be involved in treatment/discharge planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. The provider shall submit an active discharge plan to the MCO, MMP or the BHSA for review prior to the member's discharge. Once the MCO, MMP or the BHSA approves the discharge plan, the residential treatment service provider shall begin collaborating with the member or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments as needed. Once the MCO, MMP or the BHSA approves the discharge plan, the provider shall begin collaborating with the member or legally authorized representative and the treatment team to prepare the member for referral into another level of care, post treatment return or reentry into the community, or the linkage of the member to essential community treatment, housing, recovery, and human services. The provider shall request written permission from the member or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The provider shall request information from post-discharge providers to establish that the planning of services and activities has begun. The provider shall inform the MCO, MMP or the BHSA of all scheduled appointments post discharge, and shall notify the MCO, MMP or the BHSA within 1 business day of the member's discharge date from their facility to help facilitate the post discharge care.

Service Units and Limitations

- ASAM Level 3.7 requires service authorization. The MCOs, MMPs and the BHSA will respond within 1 calendar day to the service authorization request. If approved, the

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MCOs, MMPs, and BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.

- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge or the member leaves the facility
- ASAM Level 3.7 may be provided concurrently with opioid treatment services. Opioid Treatment Services/Medication Assisted Treatment including medications, labs, and urine drug screens may be billed separately in community-based settings but not inpatient settings.
- One unit of service is one day.
- There are no maximum annual limits.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- Providers may not bill another payer source for any supervisory services.
- Daily supervision, including one-on-one, is included in the Medicaid per diem reimbursement.
- Residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.
- FAMIS/FAMIS MOMS/GAP do not cover residential treatment services.
- Some examples of non-reimbursable services include:
 - Remedial education (tutoring, mentoring)
 - Evaluation for educational placement or long-term placement
 - Day care
 - Psychological testing for educational diagnosis, school, or institutional admission and/or placement
 - Partial Hospitalization Programs / Intensive Outpatient Programs
 - Case management for therapy services
 - Team meetings.

Medically Managed Intensive Inpatient Services (ASAM Level 4.0)

Medically managed intensive inpatient services (ASAM Level 4.0) as defined in 12VAC30-130-5150 are acute care hospitals and shall be the designated setting for medically managed intensive

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inpatient treatment. Medically managed intensive inpatient services shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an member's use of alcohol and other drugs. Such service settings shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress, or all of these, resulting from, or co-occurring with, an member's use of alcohol or other drugs with the exception of tobacco-related disorders, caffeine abuse or dependence, or non-substance-related disorders.

ASAM Level 4.0 providers shall meet the service components as noted in this section.

Medically managed intensive inpatient services (ASAM Level 4.0) include:

- An evaluation or analysis of substance use disorders shall be provided, including the diagnosis of substance use disorders and the assessment of treatment needs for medically necessary services.
- Observation and monitoring the member's course of withdrawal shall be provided. This shall be conducted as frequently as deemed appropriate for the member and the level of care the member is receiving. This may include, for example, observation of the member's health status.
- Medication services including the prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by appropriate licensed staff who provide such services within their scope of practice or license.
- For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.

The following therapies shall be provided for reimbursement:

- Daily clinical services provided by an interdisciplinary team to stabilize acute addictive or psychiatric symptoms. Activities shall include pharmacological, cognitive-behavioral, and other therapies administered on an individual or group basis and modified to meet the member's level of understanding. For members with a severe biomedical disorder, physical health interventions are available to supplement addiction treatment. For the member who has less stable psychiatric symptoms, Level 4 co-occurring capable programs offer individualized treatment activities designed to monitor the member's mental health and to address the interaction of the mental health programs and substance use disorders.
- Health education services.

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- Planned clinical interventions that are designed to enhance the member's understanding and acceptance of illness of addiction and the recovery process.
- Services for the member's family, guardian, or significant other, as appropriate, to advance the member's treatment and recovery goals and objectives identified in the ISP.
- This level of care offers 24-hour nursing care and daily physician care for severe, unstable problems in any of the following ASAM dimensions: i) acute intoxication or withdrawal potential; ii) biomedical conditions and complications; iii) emotional, behavioral, or cognitive conditions and complications.

Discharge planning

Beginning at admission and continuing throughout the member's inpatient stay the member or legally authorized representative and the ARTS Care Coordinator of the MCO, MMP or BHSA shall be involved in treatment/discharge planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. Prior to discharge, the inpatient services provider shall submit an active discharge plan to the MCO, MMP or the BHSA for review. Once the MCO, MMP or the BHSA approves the discharge plan, the inpatient services provider shall begin collaborating with the member or legally authorized representative and the treatment team to prepare the member for referral into another level of care, post treatment return or reentry into the community, or the linkage of the member to essential community treatment, housing, recovery, and human services. The inpatient services provider shall request written permission from the member or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The inpatient services provider shall notify the MCO, MMP or the BHSA within one business day of the member's discharge date from their facility.

Medically managed intensive inpatient services (ASAM Level 4.0) co-occurring enhanced programs. These programs shall be provided by appropriately credentialed mental health professionals who assess and treat the member's co-occurring mental illness and are knowledgeable about the biological and psychosocial dimensions of psychiatric disorders and their treatment.

Service Units and Limitations

Inpatient services do not include:

- Members shall be discharged from this service when other less intensive services may achieve stabilization.
- One unit of service is one day.
- There are no maximum annual limits.

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- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- GAP does not cover inpatient services.
- Some examples of non-reimbursable services include:
 - Behavior modification;
 - Remedial education;
 - Day care; and
 - Psychological testing done for any or all of the following purposes: educational diagnosis, school recommendations, institution admission or institutional placement.
- Medically managed intensive inpatient services (ASAM Level 4.0) require service authorization. On admission, the member must meet severity of illness and intensity of service criteria for inpatient hospitalization and have a treatment plan in place that requires an inpatient level of care. The MCOs, MMPs and the BHSA will respond within 1 calendar day to the service authorization request. If approved, the MCOs, MMPs, and BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.

42 CFR PART 2

42 CFR Part 2 (<http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2>) applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that “would identify a patient as an alcohol or drug abuser ...” (42 CFR §2.12(a) (1)). In laymen’s terms, the information protected by 42 CFR Part 2 is any information disclosed by a covered program that identifies a member directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program.

With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing. Providers should consult with their own legal counsel for questions about 42 CFR Part 2.

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QUALIFIED MEDICARE BENEFICIARIES (QMBs) - COVERAGE LIMITATIONS

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the member's co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE CO-INSURANCE AND DEDUCTIBLE." The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

Providers under contract with the MMP should contact the MMP directly for more information.

QUALIFIED MEDICARE BENEFICIARIES (QMBs) - EXTENDED COVERAGE LIMITATIONS

Members in this group will be eligible for Medicaid coverage of Medicare premiums and of deductibles, co-pays and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These members are responsible for co-pay for pharmacy services, health department clinic visits, and vision services.

Providers under contract with the MMP should contact the MMP directly for more information.

CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

As described in Chapters I and VI, the Medicaid Program may designate certain members to be restricted to specific physicians and pharmacists. When this occurs, it is noted on the member's Medicaid card. A Medicaid-enrolled physician, who is not the designated primary provider, may provide and be paid for services to these members only,

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the member;
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to physicians affiliated with the non-designated primary provider in delivering the necessary services; and
- For other services covered by DMAS, which are excluded from the CMM Program requirements.

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EXHIBITS

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Medication Assisted Treatment Table

1

Medication Assisted Treatment Provided Simultaneously and Approved to be Reimbursed Separately from other ASAM Levels of Care							
MAT Services	Procedure Code	ASAM Level 2.1 and 2.5	ASAM Level 3.3 RTS	ASAM Level 3.5 RTS	ASAM Level 3.5 Inpt Psych Unit (sub- acute)	ASAM Level 3.7 RTS	ASAM Level 3.7 Inpt Psych Unit (sub- acute)
Practitioner Induction Day 1	OBOT/OTP -H0014 Non OBOT/OTP = E&M Codes	Yes	Yes	Yes	Yes	Yes	Yes
Practitioner Visits after Day 1 (OBOT/OTP and non- OBOT/OTP)	E&M Codes	Yes	Yes	Yes	Yes	Yes	Yes
Psychotherapy* for MAT	CPT Psychotherapy Codes	No, included in IOP/PHP rate	Yes	Yes	Yes	Yes	Yes
Medications	Prescription filled at Pharmacy or Dispensed on site = HCPCS Codes S0109/J0571/J0572 /J0573/J0574/J0575/J2315	Yes	Yes	Yes	No	Yes	No
Urine drug screens	80305 - 80307	Yes	Yes	Yes	No	Yes	No
Labs	CPT Codes	Yes	Yes	Yes	No	Yes	No
Care Coordination	G9012	No, included in IOP/PHP rate	No	No	No	No	No

*MAT psychotherapy must be provided through the provider of ASAM Level of Care 2.1 – 4.0 and requires a credentialed addiction treatment professional practicing within the scope of their license. This does not replace the minimum requirements for psychotherapy as required in RTS. Professionally qualified practitioners affiliated with RTS providers may bill additional psychotherapy as an ancillary service.